

**CHANGES IN HEALTH CARE SPENDING  
AMONG CHILDREN IN GEORGIA:  
IMPORTANT SHIFTS IN COVERAGE, PAYMENT STRUCTURES,  
SERVICE CONSUMPTION, AND HEALTH STATUS**



**EXECUTIVE SUMMARY**

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**With support from Healthcare Georgia Foundation, Emory University researchers examined health care spending among Georgia’s children to determine how and why spending has changed over time.**

**The analysis looked at spending in 1997 and 2004, and examined relationships between demographic factors, health status, and health spending in Georgia for children younger than 19. The results offer insights into important changes in health care access, services, and overall health, including the toll of obesity on children’s well-being.**



**Key findings:**

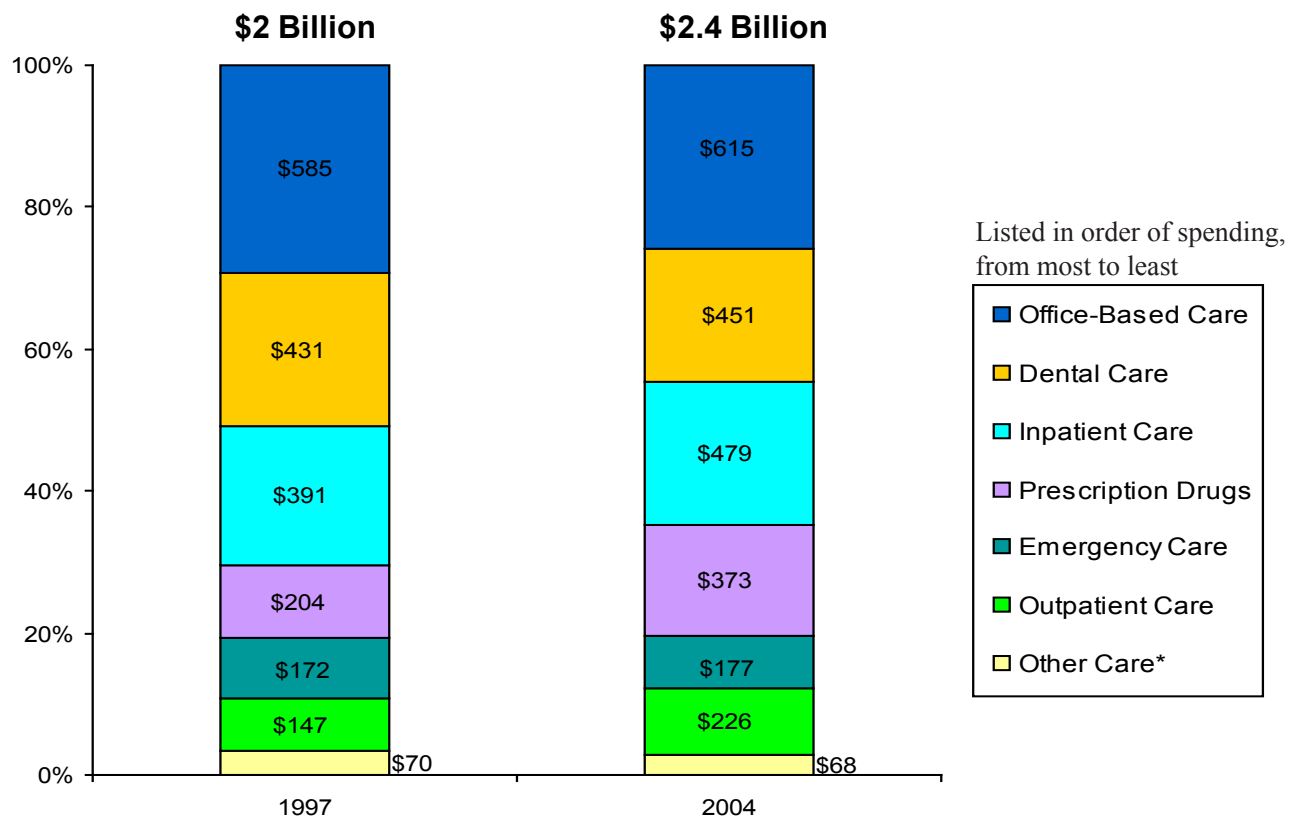
- Georgia’s population grew rapidly during the period under examination. In 1995, Georgia’s total population was estimated at 7,353,225. By 2004, that had grown to 8,921,371. The percentage of children under 18 remained constant, at about 26%, but that represents an increase from roughly 1.91 million to 2.35 million children over time.
- More children received health services in 2004 than in 1997, and total spending rose as a result. But Georgia still spent less per child than the national average. Estimated per child spending was \$1,003 in 2004, about 15% below the national average of \$1,156. This is in part because growth in per case spending in Georgia (2.2%) lagged behind the national trend (2.9%), reflecting lower medical inflation in the South compared to other U.S. regions.
- Ranked by service use, nearly 70% of children received some office-based care in 2004, more than 50% purchased prescription drugs, roughly 40% received dental care services, and more than 13% percent visited an emergency room.
- Comparisons of service use and spending reveal an overall increase in receipt of health services over the seven-year period, with the sharpest rise in office-based visits and dental care services, in terms of both percentage of the population accessing these services as well as nominal spending on them.
- At the same time, these service categories showed a substantial decrease in absolute terms in estimated costs per case. Together, these two trends provide some evidence for improved access to physician and dental care facilitated through Medicaid/PeachCare expansions, particularly via mandated oral health coverage for the newly insured.
- Although children in Georgia appear to receive a largely similar mix of services regardless of coverage type, privately insured children receive more care than children with public or no insurance, with particularly wide gaps in usage of physician and dental services.

## HEALTH SPENDING BY SERVICE TYPE

Compared to national averages, children in Georgia consumed somewhat less care across all types of medical services except for prescription medication, inpatient care, and emergency care, with the largest shortfall of 5 percentage points in the receipt of dental services. Georgia has a significantly lower average price for health services in all categories, with the exception of outpatient care. For all other types of services the estimated cost per case is 8% to 50% below the national mean, with the greatest disparities in the categories of “Other Care,” home-health expenses, and inpatient visits.

*Figure 1*, below, shows the breakdown of estimated total health spending among children in Georgia for 1997 and 2004, distinguishing among service types. In Georgia, services delivered in inpatient and outpatient settings are at the top of the cost per case list, followed by emergency room visits and dental care.

Figure 1: Distribution of Health Spending By Service Type Among Children in Georgia in 1997 and 2004 (Estimated Spending in Millions of Dollars)

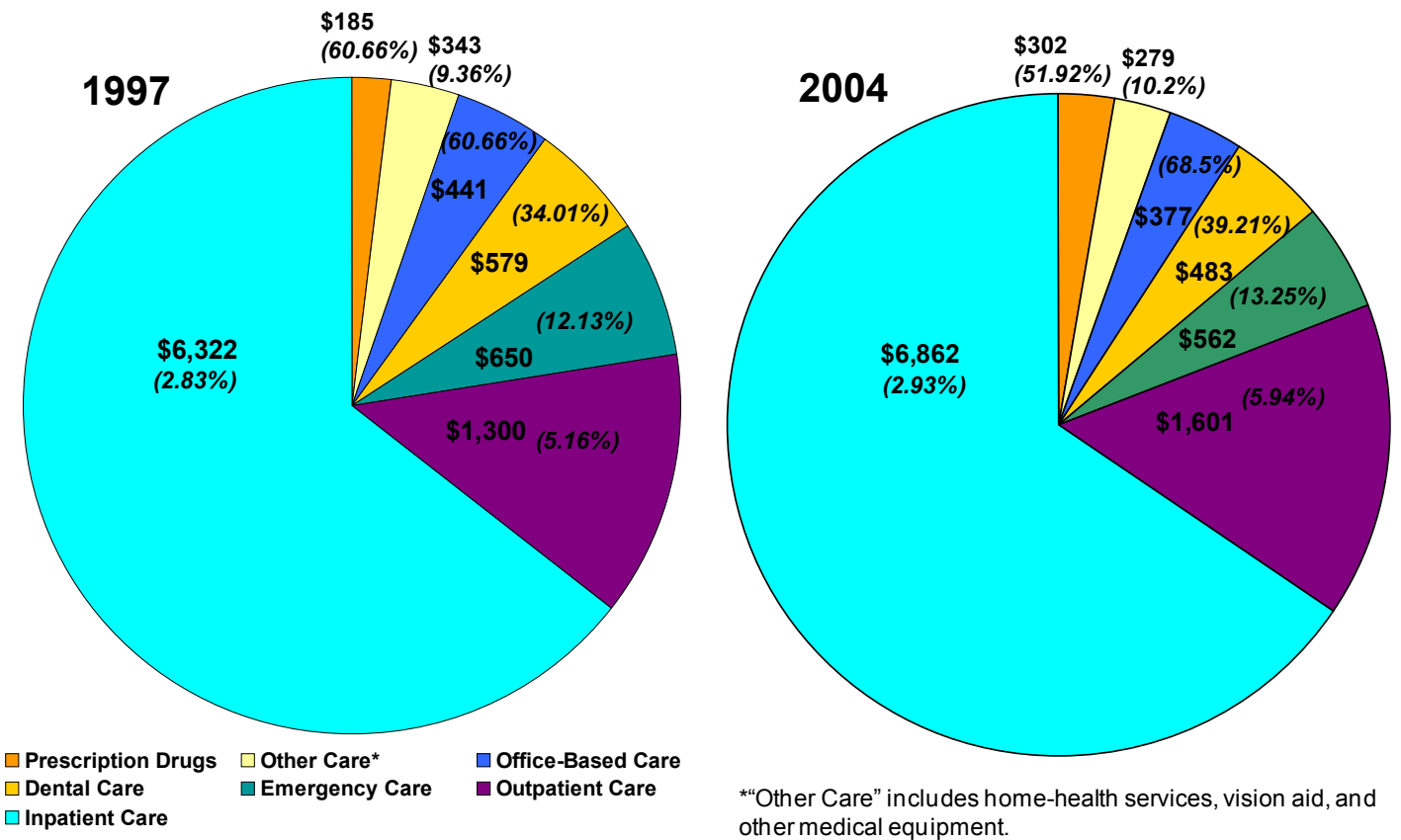


\*"Other Care" includes home-health services, vision aid, and other medical equipment.

Figure 2, below, shows the estimated cost per case by service type.

The lack of consistency across these categories is notable: Services constituting the largest proportion of spending (office-based care, inpatient care, and dental care) are not those with the highest cost per case (except for inpatient care), though they are used by the largest percentage of the population (with the exception of prescription medication). These observations thus shed light on possible avenues for cost restraint strategies and their relative effects.

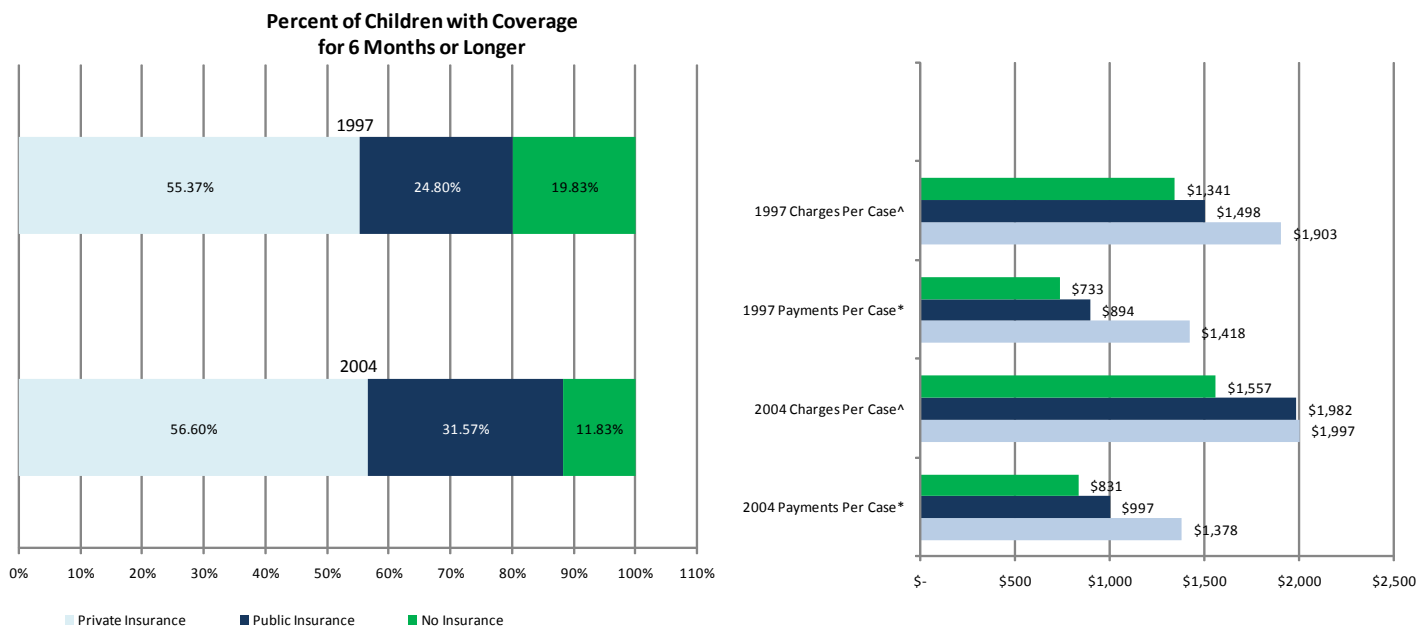
Figure 2: Estimated Cost Per Case by Service Type and (Percent Population Service Use) Among Georgia Children, 1997 and 2004



### HEALTH SPENDING BY INSURANCE STATUS AND PAYMENT SOURCE

As shown in Figure 3, on the following page, private insurance was the primary source of health coverage for a majority of children in Georgia in both 1997 and 2004. Estimated spending for this group increased by about 13% over the period. A quarter or more of all children in both years benefited from public insurance. Total estimated spending on publicly insured children increased by nearly 70%, reflecting larger numbers of children served, relative changes in their health status, as well as higher service costs and increases in payment rates. Corresponding to higher levels of public insurance, the number of uninsured children fell nearly 40%, and their estimated spending dropped 24%. It is worth noting that only half the uninsured children lacked coverage for the full year in 2004; others reported some type of insurance for at least several months.

Figure 3: Georgia Children’s Health Care Service Use and Estimated Spending by Insurance Coverage, 1997 and 2004



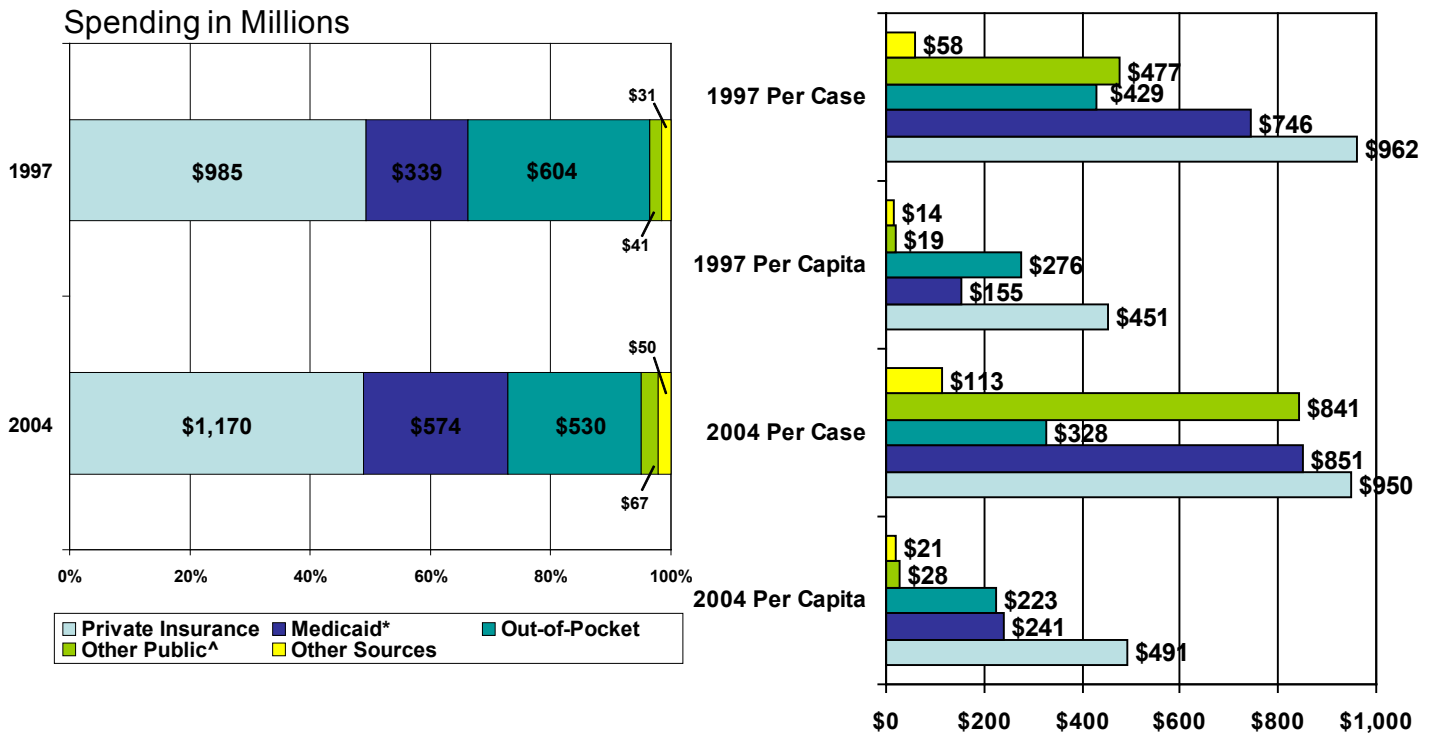
\*Charges Per Case: Charges for services received, including charges associated with uncollected liability, bad debt, and charitable care.

<sup>^</sup>Payments Per Case: Mean estimated spending among children with expenditures.

Health care spending is distributed in predictable ways across payment sources (see *Figure 4*, next page), closely matching the distribution of health insurance among children in Georgia.

- Private sources cover nearly half of all expenditures; contributions from Medicaid and family fund the remaining half along with payments from “Other Sources,” including state and federal initiatives. Out-of-pocket family contributions fell as a share of total expenditures, reflecting both lower deductibles under expanded Medicaid and somewhat lower payments under private insurance.
- Differences in prescription medication use among privately and publicly insured children grew dramatically smaller from 1997 to 2004, potentially reflecting similar low-deductible structures for prescription medicine. But the gap in prescription drug use between privately insured and uninsured children remained the same over the two periods. Given significantly lower rates of office-based care among uninsured children and the high cost of medication, it is hardly surprising that uninsured children had nearly 40% less drug consumption compared to those who were privately insured.

Figure 4: Estimated Spending and Sources of Payment for Georgia Children’s Health Services, 1997 and 2004



\*Includes Medicaid and SCHIP.

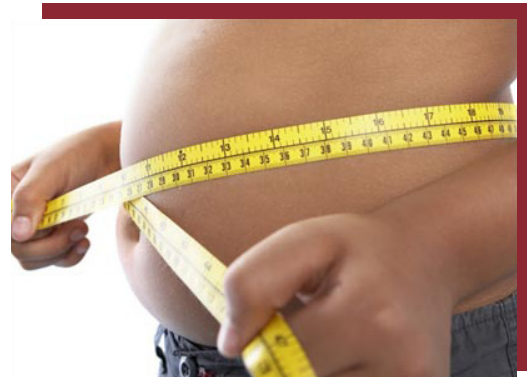
^Includes CHAMPUS, TriCare, Medicare, Veterans Administration, worker-compensation, and other federal and state programs.

## THE ROLE OF OBESITY IN HEALTHCARE SPENDING DYNAMICS

Obesity is a significant problem for adults and children across the United States, as well as in Georgia. The national prevalence of overweight among children 6-19 years in 2002 was 16%. In Georgia, 37.32% of children 6-9 years old, 26.83% of those 10-13, and 16.83% of those 14-17 were classified as overweight in 2004. Significant percentages were additionally classified as at risk for overweight: 14.47% of 6- to 9-year-olds, 18.82% of those 10-13, and 16.89% of those 14-17. Research has shown that overweight and obese children are at increased risk for a variety of medical conditions, including hypertension, high cholesterol, diabetes, gastrointestinal conditions, asthma, sleep apnea, and decreased well-being. The most immediate impact of overweight on children is psychological distress and depression induced by stigmatization.

## Key findings:

- Overweight children have a higher prevalence of mental disorders, disorders of the upper gastrointestinal tract, chronic obstructive pulmonary disease (COPD), and asthma than do their peers who are normal weight or underweight.
- At-risk children have higher rates of trauma-related disorders, infectious diseases, and skin disorders than do normal weight and underweight children.
- The burden of overweight spending (though not overweight itself) is largely concentrated among older children, with the most pronounced effect on spending among children older than 13 years.
- Obesity-attributable expenditures amounted to nearly \$30 million in 2004 for the subpopulation of overweight children ages 13-17 years.
- Obesity appears to have been responsible for nearly 6% of total expenditures for the group and accounted for 1.25 % of total health spending for children in Georgia that year.



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